



Phone 480-585-0804  
 Suite #367  
 9377 East Bell Road  
 Scottsdale, AZ 85260

**Desert Mountain OB/GYN, PC**

## MEDICAL RECORDS AUTHORIZATION RELEASE

PATIENT NAME: \_\_\_\_\_

PRIOR NAME: \_\_\_\_\_  
 (If seen under another name)

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

SOCIAL SECURITY NO.: \_\_\_/\_\_\_/\_\_\_

I authorize: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To release my medical records to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Information to be released will consist of all your records; including your progress notes, radiology reports, labs, HIV, and other confidential tests **UNLESS OTHERWISE INDICATED IN WRITING BELOW.**

\_\_\_\_\_

I may revoke this authorization at any time by providing written notice of revocation.  
 I may not revoke the authorization retroactively for information already released.  
 I hereby waive all provisions of law and privileges relating to disclosures hereby authorized.  
 I understand that there is no charge when records are mailed to a medical provider for continuing care. I also understand a **\$25.00 fee will be charged for the copying of any records** mailed to any party other than a medical provider including myself.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Dated